DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

APR 7 2006

Glenn M. Hackbarth, Chair
Medicare Payment Advisory Commission
601 New Jersey Avenue, N.W., Suite 9000
Washington, DC 20001

Dear Mr. Hackbarth:

Pursuant to section 1848(d)(1)(E)(ii) of the Social Security Act (the Act), we are providing you with our estimate of the 2007 physician fee schedule (PFS) update, conversion factor, sustainable growth rate (SGR), and the data used in making our estimates. We currently estimate that the statutory formula used to determine the physician update will result in a 2007 PFS update of -4.6 percent. With a -4.6 percent update, the 2007 PFS conversion factor would be $36.1542. As this letter describes, underlying this update is growth in Medicare spending for physician services; during 2005, spending for physicians' services increased by 8.5 percent. Growth in the volume and intensity of physicians' services represented 7.5 percentage points of the 8.5 percent growth in total physician spending. As noted last year, we want to continue to work with the stakeholder community, particularly physicians, to review and understand these trends to see what more we can find out about the significant rate of growth. Importantly, we trust this work will help us move forward even more aggressively on the many promising ideas being advanced to help our beneficiaries get better and more efficient care.

The PFS update is set under a formula specified in section 1848(d)(4) of the Act. Using this formula, Attachment 1 shows the estimate of the update adjustment factor, and Attachment 2 shows the calculation of the estimated -4.6 percent 2007 update. Section 1848(d)(1)(E)(ii) also requires that we provide an estimate of the following year's SGR. Our current estimate of the SGR for 2007 is 0.7 percent. The SGR is the product of the Secretary's estimate of four factors. We have provided more detail on our estimates of these factors included in the SGR for 2007 in Attachment 3. These are our current estimates based on the best data available to us at this time and may be subject to revision.

The calculation of the fee schedule update depends, among other things, on the cumulative physician expenditures from 1996 to 2006. Based on our latest data, physician spending increased by approximately 8.5 percent in 2005. Table 1 of Attachment 4 shows that 7.5 percentage points of the increase in physician spending in 2005 is attributable to increases in the volume and intensity of physicians' services. Volume and intensity continued to increase during 2005 at elevated rates. In earlier years, slower growth in volume and intensity meant less pressure on the payment rates from the SGR formula. But in recent years, high rates of volume and intensity increases of 6 to 8 percent per year have exceeded the average annual 2 percent increase in the statutory volume and intensity factor in the SGR formula (real Gross Domestic

Product (GDP) per capita) during the same years, resulting in negative Medicare updates for the PFS.

Because it is important to understand the factors underlying this growth, we conducted a preliminary analysis of the 2005 increase in spending for physicians' services to pinpoint major contributors of growth.

Table 1 in Attachment 4 shows the relative contributions of the other factors to the overall 8.5 percent growth rate in 2005. The table shows that fee-for-service beneficiary enrollment increased by 0.3 percent, and fees decreased by 0.6 percent. The fee growth factor is a weighted average of the updates for the PFS (1.5 percent), laboratory (0.0 percent), and physician-administered drugs (-21.1 percent). The price of drugs decreased in 2005 as a result of the implementation of a new payment system based on competitive market prices (the average sales price) rather than regulated prices. Changes in law and regulation increased physician spending by 1.2 percent. (For 2005, this factor includes drug reform, shortage area bonuses, and coverage of certain preventive services.) Because payments to Medicare Advantage plans are not included physician spending as measured for purposes of the SGR system, Medicare Advantage payments were not a factor in the SGR spending growth. Growth for 2004 has been revised to be 11.4 percent. This figure is lower than the 15.2 percent growth reported to you last year. The revised figure is based on actual data rather than projections.

As shown in the table 2 in Attachment 4, the vast majority of the 2005 spending growth is attributable to the following areas:

- An increase in spending for evaluation and management (E&M) services accounted for 2.6 percentage points, or 31 percent, of the overall spending growth of 8.5 percent. E&M's 31 percent share of the overall spending growth is smaller than its 37 percent share of overall spending in part due to the relatively slower growth rate for these services; the 7 percent growth rate for E&M services was substantially less than the growth rate for other types of services.

- An increase in spending for procedures accounted for 2.5 percentage points or 29 percent of the overall spending growth. More than 1 percentage point of this growth is attributable to spending increases in the sub-category of Minor Procedures. Within Minor Procedures, the fastest growing procedures include physical therapy, podiatry, and dermatology codes.

- An increase in spending for imaging services accounted for 2.3 percentage points or 27 percent of the overall spending growth. At 16 percent, 2005 growth in imaging services is significantly higher than the 8.5 percent average growth.

- For 2005, spending on laboratory and other tests grew by 11 percent, accounting for 1.3 percentage points or 15 percent of the overall spending growth.

- Spending on SGR-related drugs decreased by 3 percent, accounting for -0.3 percentage points of the overall spending growth.

- While spending on "other" services represents only 1 percent of spending and accounts for 0.3 percent of overall spending growth, such services grew by 20 percent.

Table 3 shows that over the past several years there has been an increasing proportion of office visits in higher-level E&M codes. For example, in 2001 the two lowest level office visits accounted for 22 percent of total office visits, but this percent decreased to 17 percent in 2005. Similarly, the highest two levels of visits accounted for 24 percent of total office visits in 2001, but this figure increased to 31 percent of total office visits by 2005. Table 4 isolates the growth in the volume and intensity of office visits after controlling for growth in beneficiary enrollment and fee changes. Even with these trends, payments for E&M codes grew relatively slowly, compared to other types of physicians'services. In contrast, procedures, laboratory tests, and imaging grew at a much more rapid rate. Tables 5 and 6 provide additional information regarding some of the other specific services that grew much more rapidly and contributed significantly to increases in physician spending during 2005.

These numbers are preliminary and may be revised as more complete data becomes available and we examine the spending trends more closely. However, they indicate that the major contributors to the increase in spending appear to continue to be certain diagnostic and therapeutic services, including services particularly important in the treatment of the growing number of Medicare beneficiaries with chronic illnesses: more frequent and more intensive follow-up visits; more frequent and more complex imaging services; more frequent and more intensive minor procedures such as physical therapy; and more frequent and intensive utilization of physician-administered drugs. Understanding the relatively rapid growth in these services, and determining whether there are ways to promote better health while slowing the rapid increase in use of these services, is an increasingly important issue.

As MedPAC has noted, the current physician payment system focuses on payment for individual services but does not provide payments that support physician efforts to combine services furnished to beneficiaries efficiently in an episode of care, or furnished during a period of time to treat chronic disease. As a result, physicians may find it difficult to invest in activities like electronic record systems and support programs for high-risk patients that could enhance quality of care, without increasing medical costs.

Consequently, we support MedPAC's general recommendation for the development of measures related to the quality and efficiency of care by individual physicians and physician groups. Using these measures to identify and provide better support for high-quality, efficient care could potentially avoid some tests, procedures, and even physician visits, while reducing complications and improving outcomes.

The foundation of effective initiatives to provide better support for quality care and efficiency is collaboration with physicians and physician groups. This collaboration helps ensure that valid quality and resource use measures are used, that physicians are not being pulled in conflicting directions, and that physicians get support that helps them deliver care more effectively and at a lower cost. Consequently, to develop and implement these initiatives, we are working with a wide range of physicians and physician groups who share our goal of improving quality and avoiding unnecessary health care costs.

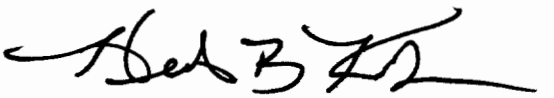
We recognize that such steps toward supporting better care, not just paying more for more care, still require further development. A comprehensive set of performance measures, including efficiency measures, is not yet available. Using existing measures and developing improved measures in Medicare's payment systems will require continued effort and extensive interaction with stakeholders. In collaboration with our physician partners, we are developing plans that would enable us to move forward to implement payment reforms that help achieve better quality and lower costs. The significant continuing growth in physician spending highlights the urgent need for progress toward this goal.

The President's Budget indicates support for linking quality reporting and improvement to Medicare payment "in a cost neutral manner." Savings from reducing care that is unnecessary or otherwise inappropriate could afford opportunities to fund enhanced payments to physicians who take effective steps to improve quality and avoid unnecessary health care costs. Payment reforms should consider the possibilities of improving care coordination and using some of the savings generated in one payment system to fund incentives in another, as long as these reforms do not provide inappropriate incentives.

We will provide a more detailed explanation of the SGR and PFS updates on the Center for Medicare & Medicaid Services Web site http://www.cms.hhs.gov/SustainableGRatesConFact/).

All of the data contained in this letter and additional SGR-related information is available to the public in the Web site document.

Sincerely,



Herb B. Kuhn
Director
Center for Medicare Management

Attachments

Attachment 1

Under section 1848(d)(4) of the Social Security Act, the update for 2007 is equal to the Secretary's estimate of the Medicare Economic Index adjusted by an update adjustment factor and a statutory factor. The formula for the calculation of the update adjustment factor is shown below. The calculation of the update is detailed on the next page.

Estimate of the Update Adjustment Factor

$$UAF_{07} = \frac{Target_{06} - Actual_{06}}{Actual_{06}} \times .75 + \frac{Target_{4/96-12/06} - Actual_{4/96-12/06}}{Actual_{06} \times SGR_{07}} \times .33$$

UAF_{07} =Update Adjustment Factor for 2007
$Target_{06}$ =Allowed Expenditures for CY 2006 =$81.7 billion
$Actual_{06}$ =Estimated Actual Expenditures for CY 2006 =$97.4 billion
$Target_{4/96-12/06}$ =Allowed Expenditures from 4/1/1996 - 12/31/2006 =$693.6 billion
$Actual_{4/96-12/06}$ =Estimated Actual Expenditures from 4/1/1996 - 12/31/2006 =$714.0 billion
SGR_{07} =0.7 percent

$$\frac{\$81.7 - \$97.4}{\$97.4} \times (.75) + \frac{\$693.6 - \$741.0}{\$97.4 \times 1.007} \times (.33) = -28.0\%$$

Our current estimate of the update adjustment factor is -28.0 percent. Section 1848(d)(4)(D) of the Social Security Act indicates that the update adjustment factor may not be less than -7 percentage points. Consistent with the statute, in the physician fee schedule final rule for 2007 we will limit the update adjustment factor to -7 percentage points if the above formula produces an update adjustment factor that would exceed this value.

Attachment 2

Estimate of the 2007 Physician Fee Schedule Update

(1)	Medicare Economic Index	2.6% (1.026)
(2)	Update Adjustment Factor	-7.0% (0.930)
(3)	Update	-4.6% (0.954)

Note: The figures on lines 1 and 2 are multiplied to produce the update of -4.6 percent on line 3.

Attachment 3

Estimate of the 2007 Sustainable Growth Rate (SGR)*

(1) Estimated Change in Fees	2.6%	(1.026)
(2) Estimated Change in Fee-for-Service Enrollment	-2.9%	(0.971)
(3) Estimated Change in Real GDP Per Capita	2.2%	(1.022)
(4) Estimated Change in Law or Regulation	-1.0%	(0.990)
(5) Estimated 2007 SGR	0.7%	(1.007)

Note: The figures on lines 1-4 are multiplied to produce the estimated SGR value of 0.7 percent on line 5.

* These figures represent current estimates only and may change based on new information in a *Federal Register* notice that we expect to publish no later than November 1, 2006.

Attachment 4

Analysis of the Growth in Volume and Intensity of SGR-Related Services

While the overall rate of SGR-related expenditure growth decreased from 11.4 percent in 2004 to an estimated 8.5 percent in 2005, this drop can be explained by decreased growth in beneficiary enrollment (net of beneficiaries in Medicare Advantage plans), legislation and lower fees. Changes in legislation that have an impact on 2005 spending are the Medicare Modernization Act provisions for drug reform, HPSA bonuses, and three new benefits: the initial preventive physical examination and coverage of certain cardiovascular and diabetes tests. Changes in fees reflect the weighted average payment updates for the physician fee schedule, laboratory services, and physician administered drugs. The volume and intensity of services continued to grow at a high rate, and they are a significant factor in the growth of SGR-related expenditures.

Table 1: 1998-2005 Factors of SGR-Related Expenditures Growth

	1998	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**
Total Expenditures (dollars in billions)	$50.1	$52.6	$58.1	$66.3	$70.9	$78.2	$87.1	$94.5
Total Growth	1.5%	5.3%	10.3%	14.2%	7.0%	10.2%	11.4%	8.5%
Factors:								
Fees	2.1%	2.2%	4.9%	4.5%	-3.8%	1.4%	0.1%	-0.6%
Beneficiary Enrollment	-2.2%	-0.6%	0.9%	3.1%	2.9%	2.3%	1.3%	0.3%
Legislation	0.0%	0.4%	0.8%	0.1%	1.0%	0.0%	1.7%	1.2%
Volume and Intensity	1.6%	3.3%	3.4%	5.9%	7.1%	6.2%	8.0%	7.5%
GDP per capita (10-yr moving average)	1.8%	1.9%	2.0%	2.2%	2.1%	2.0%	2.3%	2.3%
V&I less GDP	-0.2%	1.4%	1.4%	3.7%	5.0%	4.3%	5.8%	5.2%

Spending Growth Related to the Sustainable Growth Rate

The following table shows the relative impact of various services on the 8.5 percent increase in actual expenditures from 2004-2005 related to the Sustainable Growth Rate (SGR).

Actual expenditures were compared using Berenson-Eggers type of service (BETOS) categories, a system that categorizes each procedure code into clinical categories. While evaluation and management services (primarily physician visits) have the greatest overall impact on the increase in actual expenditures, their 7 percent growth rate was slower than for other major categories. As a result, the 31 percent contribution of evaluation and management services of overall spending growth is less than the 37 percent share of total physician spending represented by such services.

Procedures rank second in contributing toward the increase. Procedures represent 26 percent of spending and 29 percent of the 2005 increase in spending. Imaging services rank third in

contributing to the increase. Imaging services by far had the highest growth rate of 16 percent, almost twice the 8.5 percent overall growth rate. While imaging services represent 14 percent of spending, they account for 27 percent of the increase in spending. Laboratory and other tests are the fourth largest contributor to the increase.

Table 2: Spending Growth by Type of Service from 2004 to 2005

Type of Service	Growth Rate	Percent of Spending	Contribution to Increase	Percent of Increase
Evaluation and Management	7%	37%	2.6%	31%
Procedures	9%	26%	2.5%	29%
Imaging	16%	14%	2.3%	27%
Lab and Other Tests	11%	12%	1.3%	15%
Drugs (under the SGR)	-3%	9%	-0.3%	-4%
Other Services	20%	1%	0.3%	4%
Total	8.5%	100%	8.5%	100%

Table 2 shows that spending on SGR-related drugs decreased. However, the bulk of this decrease is attributable to the revisions in drug pricing in 2004 and 2005. Table 2a shows that growth in the volume and intensity of physician-administered drugs more than offset the 2005 revisions in drug pricing.

Table 2a: 2003-2005 Growth in Physician-Administered Drug Spending

Factors of Drug Spending	2003	2004	2005
Drug Pricing	1.9%	-11.7%	-21.1%
Beneficiary Enrollment	2.6%	1.3%	0.2%
Volume and Intensity	18.8%	24.6%	22.7%
Total	24.2%	11.5%	-3.0%

Analysis Of the Spending Increases By Sub-Categories and Selected Procedure Codes

We explored the underlying data of the top three categories contributing to overall growth: evaluation and management, procedures, and imaging.

Procedure Code Analysis (Evaluation and Management – Established Patient Office Visits)

Over the past several years there has been an increasing proportion of office visits in higher-level evaluation and management (E&M) codes. For example, the following table illustrates that, in 1998, of all E&M visits with established patients in physicians' offices, 18 percent of allowed services were Level 2 visits, and 21 percent were Level 4 visits. By 2005, only 12 percent were Level 2 visits, and 28 percent were Level 4 visits. That is, there has been an upward shift in the

complexity of billed office visits, with a net increase in the share of office visits at the more complex level. Similar trends occur for other types of E&M visits.

Table 3: Distribution Across Levels of Office Visits for Established Patients

Codes	1998	1999	2000	2001	2002	2003	2004	2005
99211	5%	5%	5%	6%	6%	6%	5%	5%
99212	18%	17%	17%	16%	15%	13%	12%	12%
99213	52%	53%	54%	54%	54%	53%	53%	52%
99214	21%	21%	21%	21%	22%	24%	26%	28%
99215	4%	4%	3%	3%	3%	3%	3%	3%

An analysis of the factors of growth in established patient office visits further emphasizes this continued growth in volume and intensity of evaluation and management services.

Table 4: 2003-2005 Factors of Growth in Established Patient Office Visits (99211-99215)

Factors of Expenditure Growth	2003	2004	2005
Fees	1.4%	1.5%	1.5%
Beneficiary Enrollment	2.6%	1.3%	0.2%
Volume and Intensity	3.2%	5.3%	3.6%
Total Growth in Established Patient Office Visits	7.3%	8.3%	5.4%

Procedure Code Analysis (Procedures - Minor Procedures)

The increase in Procedures is dominated by the increase in the sub-category of Minor Procedures. The largest contributors to the increase in this sub-category are physical therapy, dermatology, and podiatry codes. Table 5 shows the increases in charges and services during 2005 for nine Minor Procedures that each contributes 0.03 percentage points or more to growth in overall spending.

Table 5: Minor Procedures that Contributed to the Total Increase in Spending

Code	Description	2005 Charges (in millions)	Increase in Services	Increase in Charges	Percentage of Total SGR Spending	Contribution to Total Increase in SGR Spending
97110	Therapeutic exercises	$1,004	25.7%	23.5%	1.06%	0.25%
97140	Manual therapy	$377	32.1%	32.9%	0.40%	0.13%
97112	Neuromuscular reeducation	$164	37.3%	41.6%	0.17%	0.07%
64475	Inj paravertebral l/s	$77	30.0%	68.2%	0.08%	0.06%
20610	Drain/inject, joint/bursa	$273	15.5%	17.9%	0.29%	0.05%
17304	1 stage mohs, up to 5 spec	$242	16.5%	19.7%	0.26%	0.05%
64483	Inj foramen epidural l/s	$108	26.8%	36.2%	0.11%	0.04%
97530	Therapeutic activities	$194	15.0%	19.0%	0.21%	0.04%
11721	Debride nail, 6 or more	$268	5.9%	11.0%	0.28%	0.03%
	Other Minor Procedures	$3,644	23.0%	9.9%	3.86%	0.38%
Total	**All Minor Procedures**	$6,351	23.4%	15.6%	6.72%	1.05%

Service Code Analysis (Imaging Procedures)

Table 6 shows that imaging services represent 14 percent of 2005 Medicare physician spending and grew at 16 percent during 2005. Table 6 also shows growth rates for four subcategories of imaging services: standard imaging, advanced imaging, echography, and imaging procedures.

The advanced imaging category is largely comprised of CAT scans and MRI procedures. Spending for these services grew by 25 percent during 2005. Advanced imaging procedures account for 1.3 percentage points of the 8.5 percent increase in 2005 physician spending.

The imaging procedures category includes services such as cardiac catheterization, fluoroscopy, and 3-D holographic reconstruction. This category represents 1 percent of 2005 Medicare physician spending. Spending for this category of services increased by 20 percent during 2005.

Spending for echography procedures comprised 3 percent of 2005 Medicare physician spending. Spending for this category of services increased by 17 percent during 2005.

The standard imaging category includes services such as chest x-rays as well as contrast gastrointestinal imaging, nuclear medicine procedures, and PET scans. This category represents 5 percent of 2005 Medicare physician spending. Spending for this category of services increased by 8 percent during 2005.

Table 6: Adjusted Spending Growth in Imaging Services by BETOS

Types of Imaging Services	2003 Growth Rate	2004 Growth Rate	2005 Growth Rate	Percent of 2005 Spending	2005 Contribution to Increase
Standard Imaging	15%	15%	8%	5%	0.4%
Advanced Imaging	20%	21%	25%	5%	1.3%
Echography	13%	13%	17%	3%	0.6%
Imaging Procedure	10%	11%	20%	1%	0.1%
Total Imaging	16%	16%	16%	14%	2.3%

Beginning with 2006, CMS established a multiple procedure payment policy for certain diagnostic imaging services. In order to more accurately reflect the reduced costs of the second procedure when two imaging services are furnished on contiguous body parts in the same session with the patient, the policy reduces the payments for such procedures. While the regulation was accomplished in a budget-neutral manner, the Deficit Reduction Act (DRA) of 2005 eliminated the budget-neutrality provision. In addition, the DRA caps physician fee schedule payments that exceed hospital outpatient department (HOPD) payments at the HOPD payment level for certain imaging services. This policy applies to X-ray, ultrasounds, nuclear medicine, MRI, CT, and fluoroscopy services. Screening and diagnostic mammograms are exempt from this policy change.